ATTACHMENT 7c

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
RECIPIENT	IM	A	1234567890	64

PROVIDER INFORMATION

⑥ THERAPIST'S NAME AND CREDENTIALS	⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, M.S.	12345678	(XXX) XXX - XXXX

⑨ I.M. REFERRING/PRESCRIBING
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☐ Physical Therapy ☐ Occupational Therapy ☑ Speech Therapy

B. Total time per day requested 30 min.
Total Sessions per week requested 2
Total number of weeks requested 26

C. Provide a description of the recipient's diagnosis and problems and date of onset.

CEREBRAL PALSY SINCE BIRTH. SUFFERS FROM VASCULAR HYPERTENSION, DEGENERATIVE JOINT DISEASE, DIVERTICULOSIS OF COLON, SUBACUTE CHOLECYSTITIS AND CHOLEITHIASIS.

D. BRIEF PERTINENT HISTORY:

64 YEAR OLD FEMALE WITH CEREBRAL PALSY. SHE HAS BEEN A RESIDENT OF I.M. PROVIDER NURSING HOME SINCE 11/82. SHE IS INVOLVED IN MANY ACTIVITIES IN THE NURSING HOME AND ATTENDS SCHOOL 3 DAYS A WEEK WHERE THEY CALL HER A "LEADER". SHE IS MOTIVATED AND STRIVES TO BE THE BEST SHE CAN.

Location	Date	Problem Treated

E. Therapy History

PT

N.A.

OT

N.A.

SP

RECEIVED SPEECH THERAPY SINCE 1/86. P.T. SINCE 2/86, also at I.M. PROVIDER NURSING HOME.

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation).

NO FORMAL EVALUATIONS FOUND IN HER CHART PRIOR TO 11/86.

2/87 - ORAL MECHANISM EXAMINATION REVEALED REDUCED TONGUE, LIP AND JAW MOVEMENTS. NORMAL PHONATION FOR THIS POPULATION IS 16.0 SECONDS (CAMPBELL AND BLESS 1980). DIADOCKOKINETIC RATES (AMR AND SMK) WERE SLOW, DYSRYTHMIC UNEVEN IN LOUDNESS AND COUNTABLE. THIS REDUCED HER INTELLIGIBILITY SIGNIFICANTLY.

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

SHE WAS GIVEN A COMMUNICATION BOOKLET TO USE IN NOV. 1986. SHE REPORTS THAT HER USE OF THE BOOKLET IS MINIMAL DUE TO THE FACT THAT SHE DOESN'T LIKE IT. THERAPY FOCUSED ON ARTICULATION ONLY PREVIOUS TO 11/86.

SINCE 2/87 THERAPY HAS FOCUSED ON ORAL EXERCISES TO INCREASE ORAL MUSCULATIVE STRENGTH AND CONTROL. HER LIP AND TONGUE MOVEMENTS HAVE INCREASED SIGNIFICANTLY IN THAT SHE IS NOW 70% INTELLIGIBLE ON THE PHONEMES.

Date: 9/1/87

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

1) IMPROVE ORAL MUSCULATURE STRENGTH AND CONTROL.

2) IMPROVE COMPENSATED INTELLIGIBILITY TO 80%.

3) INCREASE USE OF COMMUNICATION BOOKLET TO STAFF AND SCHOOL TEACHERS FOR BETTER COMMUNICATION.

I. Rehabilitation Potential:

GOOD - SHE IS MOTIVATED TO IMPROVE HER SPEECH.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. L.M. Prescribing
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

MM/DD/YY
Date

L.M. Performing
Signature of Therapist Providing Treatment

MM/DD/YY
Date